



General

Guideline Title

Female sexual health consensus clinical guidelines.

Bibliographic Source(s)

Lamont J, Bajzak K, Bouchard C, Burnett M, Byers S, Cohen T, Fisher W, Holzapfel, Senikas V. Female sexual health consensus clinical guidelines. J Obstet Gynaecol Can. 2012 Aug;34(8):S1-56. [358 references]

Guideline Status

This is the current release of the guideline.

Recommendations

Major Recommendations

The quality of evidence assessment (I-III) and classification of recommendations (A-L) are defined at the end of the "Major Recommendations" field.

Introduction

Summary Statements

- Sexual concerns are prevalent in the population. (II-1)
- Many women have to look outside medicine for solutions to their sexual concerns. (II-1)
- Many health care providers have the ability to deal with sexual health issues. (II-3)
- Health care providers need a better understanding of female sexual issues/problems. (II-3)

Chapter 1: Sexuality Across the Lifespan

Childhood and Adolescence

Summary Statements

- Children are sexual from birth. Expression of sexuality is a developmental process. (II-2)
- Most discourse on adolescent sexuality focuses on the potential for adverse consequences such as exploitation, sexual assault, unwanted pregnancy, and sexually transmitted infections, and has generally neglected to communicate to girls that expression of sexuality and sexual experimentation are normal and healthy. (II-2)
- Age-appropriate sexual expression is a positive part of the development of adolescent girls. Negative, coercive, and discriminatory

experiences can detrimentally affect sexual well-being. (II-2)

- Variations exist in same-sex and opposite-sex sexual behaviour; same-sex and opposite-sex sexual behaviour is not equivalent to self-definition as heterosexual or lesbian or bisexual. Some women who have sex with women may be reluctant to define themselves as lesbian because women who identify themselves or who are identified by others as lesbian or bisexual may experience social discrimination. (II-2)

Recommendations

1. Health care providers should encourage adolescents to use condoms consistently, and to take other steps to promote sexual health and prevent sexually transmitted infections (e.g., human papillomavirus vaccination), even while they are in a relationship. (II-3A)
2. Health care providers should be well informed about the variability of normal patterns of sexual development before evaluating sexual concerns that pertain to children and adolescents. (II-3A)
3. Health care providers should balance concern about adverse sexual consequences for girls with positive messages about adolescent girls' expression of their sexuality. (II-3A)

Forming a Long-Term Relationship

Summary Statements

- Women express their sexuality in a variety of ways and in a variety of situations, including with a partner and through masturbation. (II-2)
- Masturbation and self-pleasuring can be important for self-knowledge and as a sexual outlet in themselves for women who have and those who do not have a partner. (III)
- Relationship factors have a major influence on a woman's sexual well-being. (II-2)

Recommendations

4. Health care providers should consider the effect of the relationship when assessing a woman's sexual well-being. (III-A)
5. Health care providers should strive to make their offices open and welcoming environments for women of all sexual preferences and practices. (III-A)

Pregnancy and Child-Bearing

Summary Statements

- Pregnancy and breastfeeding, as well as experience with infertility, can affect sexual functioning. (II-2)

Recommendations

6. Health care providers should discuss sexuality at the early prenatal visit, before discharge from the hospital postpartum, and at the postnatal check-up. (III-A)
7. Health care providers should
 - Communicate that they are open to discussing sexual concerns
 - Educate patients about normal fluctuations in sexual interest and frequency
 - Discuss the range of non-coital sexual activities if intercourse is difficult, painful, or prohibited for medical reasons
 - Emphasize the importance of the quality of lovemaking rather than coital frequency to sexual satisfaction (III-A)
8. Health care providers should provide advice to support sexual adjustment and deal with challenges to sexual function during pregnancy and childbirth (e.g., suggest adapting coital position to accommodate changing body shape, suggest topical lubricant to reduce dyspareunia postpartum). (III-A)
9. Health care providers should help women deal with their concerns related to breastfeeding and sexual activity. This should include providing reassurance about the hormonal causes of erotic feelings during breastfeeding and informing women that if they are distressed by milk ejection during orgasm, this can be reduced by emptying the breast before sexual activity. (III-A)

Aging and Menopause

Summary Statements

- Decline in frequency of sexual activity at menopause does not alter women's potential for desire, arousal, orgasm, sexual pleasure, or sexual satisfaction. (II-2)
- Psychological, relationship, social, cultural, and biological factors affect women's sexual well-being as they age and experience menopause. (II-2)

- Most women with a partner continue to engage in sexual activity. Women often cease sexual activity not because of lack of interest but because they do not have a partner. (II-2)

Recommendations

10. The health care provider should enquire about both the woman's functioning and her partner's functioning in assessing changes to sexual activity with menopause and aging. (II-1A)
11. Changes in sexual functioning should be treated only if the woman expresses distress about these changes. (II-3B)
12. Health care providers should recommend the use of a lubricant or estrogen (local or systemic) for problems arising from vaginal dryness. (II-1A)
13. Health care providers should discuss safer sex, particularly with newly single women. (II-2A)

Chapter Summary Statements

- Women's sexuality may be affected by biological events (e.g., puberty, childbirth, menopause, and aging), by their own psychology/psychological health, by their ethnicity and culture, and by their sexual orientation. (III)
- Whether or not women's sexual desire and activity continue through periods of pregnancy, childrearing, menopause, and aging may depend on the presence of a partner, a partner's sexual function, the quality of the relationship, and both partners' general health. (III)
- There is considerable variation in the patterns of girls' and women's sexual expression and experience. (II-2)

Chapter Recommendations

14. Health care providers should understand that all women are sexual and acknowledge that women have sexual needs. (III-A)
15. Health care providers should have an understanding of and respect for diverse individual patterns of sexual behaviour and orientation across the lifespan. (III-A)
16. Couples should be encouraged to include sexual pleasuring without penetration in their activities if penetration is impossible. (III-A)
17. Health care providers should recognize the need for sensitivity to a woman's life stage, to her individual situation, and to her sexual orientation when they assess sexual health concerns. (III-A)

Chapter 2: Approach to Assessment

Assessment of Sexual Concerns in a General Clinician's Office

Recommendations

18. Health care providers should regard the identification and management of a woman's sexual health issues as important and legitimate elements of her clinical care (II-2A)
19. Health care providers should ensure they have and apply the skills and knowledge necessary to assess and manage a woman's sexual health problems. (III-A)
20. Health care providers should provide a clinical environment in which women feel they can discuss their sexual concerns. (III-A)
21. Health care providers should establish a list of clinical sexual health resources in the community for referral when necessary. (III-A)

Chapter 3: Management of Sexual Concerns

A General Approach to Management

Summary Statements

- Effective management of sexual concerns requires a biopsychosocial approach that includes both medical and counselling skills. (II-3)
- A limited problem-focused approach, sometimes called the Twenty-Minute Hour, can be used to assess and manage sexual concerns effectively without disruption of the office schedule. (II-3)
- The PLISSIT (permission, limited information, specific suggestions, intensive therapy) approach can be used to determine the level of intervention required. (II-3)
- Involvement of the partner can often enhance outcomes in managing sexual health concerns. (II-3)

Recommendations

22. All health care providers should include screening questions regarding sexual well-being as a standard of practice. (II-3A)
23. Health care providers who lack confidence in taking a biopsychosocial approach to counselling on sexual health concerns should seek additional training. (III-B)

24. Health care providers should involve the woman's partner in the assessment and treatment of sexual health concerns when it is appropriate and safe to do so. (III-A)

Chapter 4: Health Concerns that Affect Female Sexuality

Benign Gynaecological Concerns

Summary Statement

- Despite the many types of gynaecological surgeries, our understanding of the postoperative sexual physiologic changes and consequent effects on sexual function is rudimentary at best. (II-2)

Recommendations

25. Health care providers should advise women that surgery for benign gynaecologic conditions improves sexual function in the majority of women but that a small group may experience detrimental effects on their sexuality. (II-2A)

Gynaecological Cancers

Summary Statement

- Health care providers need to address both the physical and the psychological components of cancer as they relate to sexuality. Pain related to the disease and/or the treatment may inhibit sexual desire, and the disease and/or the treatment may make sexual activity painful. (III)

Recommendation

26. Health care providers should involve the woman's partner in addressing sexual issues, with attention being paid to basic sexual adjustments (i.e., timing, positioning, lubrication, non-coital lovemaking). (III-A)

Chronic Conditions

Summary Statement

- Medical illnesses and their treatment can have effects on the sexuality of both the woman and her partner. (II-3)
- Chronic illness can cause physical and emotional changes, both of which can affect female sexuality. (II-3)

Recommendations

27. Health care providers should consider the implications of medical conditions and their treatment on women's sexuality. (II-3A)
28. Clinicians caring for women with chronic illnesses should integrate information about sexual care into their medical therapy. (II-3A)

Chapter 5: Coital Pain

Summary Statements

- Coital pain is common and is likely to have a negative effect on a woman's sexual function. (II)
- Vulvar pain may arise from visible, intermittently visible, or non-visible lesions. (III)

Recommendations

29. The diagnosis of vulvar pain syndromes should be aided by a focused history that is based on a plausible differential diagnosis and by careful, repeated examinations. (III-B)
30. Women complaining of vulvar pain should be advised to avoid irritants and should be offered symptomatic treatment. (III-A)
31. Directed and empiric therapy should be provided when a specific diagnosis is suspected. (III-B)

Chapter 6: Sexual Desire Disorders

Assessment of Women's Hypoactive Sexual Desire Disorder

Summary Statements

- Lowered desire accompanied by distress (hypoactive sexual desire disorder) is highly prevalent and is most common in mid-life. (II-1)
- Treating medical, psychological, and relationship problems, addressing sociocultural issues, and providing androgen therapy when

appropriate can be effective in helping women and their partners dealing with hypoactive sexual desire disorder. (I)

- Distressing female hypoactive desire is context-dependent, and this needs to be considered in treatment planning. A woman's sense of connection to her partner and her own psychological and physical health are more closely linked to desire than are estrogen and testosterone. (II-2)

Recommendations

32. Health care providers should give women the opportunity to discuss their sexual concerns at the beginning of a therapeutic process. (III-A)
33. Health care providers should consider caring for women with hypoactive sexual desire, rather than referring them, even if they require the assistance of an interdisciplinary team. (III-A)
34. Well-designed and adequately powered studies should be carried out to assess the health benefits and long-term risks of androgen therapies for women with hypoactive sexual desire. (III-L)

Definitions:

Quality of Evidence Assessment*

I: Evidence obtained from at least one properly randomized controlled trial

II-1: Evidence from well-designed controlled trials without randomization

II-2: Evidence from well-designed cohort (prospective or retrospective) or case-control studies, preferably from more than one centre or research group

II-3: Evidence obtained from comparisons between times or places with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of treatment with penicillin in the 1940s) could also be included in this category

III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees

*Adapted from the Evaluation of Evidence criteria described in the Canadian Task Force on Preventive Health Care.

Classification of Recommendations†

A. There is good evidence to recommend the clinical preventive action

B. There is fair evidence to recommend the clinical preventive action

C. The existing evidence is conflicting and does not allow to make a recommendation for or against use of the clinical preventive action; however, other factors may influence decision-making

D. There is fair evidence to recommend against the clinical preventive action

E. There is good evidence to recommend against the clinical preventive action

L. There is insufficient evidence (in quantity or quality) to make a recommendation; however, other factors may influence decision-making

†Adapted from the Classification of Recommendations criteria described in The Canadian Task Force on Preventive Health Care.

Clinical Algorithm(s)

None available

Scope

Disease/Condition(s)

Women's sexual health conditions, including:

- Sexual dysfunction

- Coital pain
- Sexual desire disorders
- Benign gynaecological concerns (e.g., fibroids, uterine bleeding)
- Gynaecological cancers
- Infertility

Guideline Category

Counseling

Evaluation

Management

Risk Assessment

Screening

Treatment

Clinical Specialty

Family Practice

Infectious Diseases

Internal Medicine

Nursing

Obstetrics and Gynecology

Intended Users

Advanced Practice Nurses

Health Care Providers

Nurses

Patients

Physician Assistants

Physicians

Guideline Objective(s)

To establish national guidelines for the assessment of women's sexual health concerns and the provision of sexual health care for women

Target Population

Girls and women of all ages

Interventions and Practices Considered

1. Encourage consistent use of condoms to prevent sexually transmitted infections
2. Discuss sexuality
 - Early prenatal visit
 - Before discharge from the hospital postpartum
 - Postnatal check-up
3. Provide a clinical environment in which women can discuss their sexual concerns
4. Discuss sexual concerns and educate patients on sexual fluctuations and adjustments
5. Assess changes to sexual activity due to pregnancy/childbirth and menopause/aging
6. Understanding of and respect for diverse individual patterns of sexual behaviour and orientation
7. Take a biopsychosocial approach to counseling and include screening questions on sexual well-being
8. Involve woman's partner in assessment and treatment of sexual concerns
9. Advise women that surgery for benign gynaecological conditions can improve sexual function
10. Integrate information about sexual care into the medical therapy of women with chronic illnesses
11. Diagnose vulvar pain syndromes by focused history and repeated examinations
12. Advise women with coital pain to avoid irritants and offer symptomatic treatment
13. Access interdisciplinary care for women with hypoactive sexual desire
14. Refer to community sexual health resources

Major Outcomes Considered

- Women's sexual well-being
- Better understanding of female sexual issues/problems

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Searches of Unpublished Data

Description of Methods Used to Collect/Select the Evidence

Published literature was retrieved through searches of PubMed, CINAHL, and the Cochrane Library from May to October 2010, using appropriate controlled vocabulary (e.g., sexuality, "sexual dysfunction," "physiological," dyspareunia) and key words (e.g., sexual dysfunction, sex therapy, anorgasmia). Results were restricted, where possible, to systematic reviews, randomized control trials/controlled clinical trials, and observational studies. There were no language restrictions. Searches were updated on a regular basis and incorporated in the guideline to December 2010. Grey (unpublished) literature was identified through searching the websites of health technology assessment and health technology assessment related agencies, clinical practice guideline collections, clinical trial registries, and national and international medical specialty societies. Each article was screened for relevance and the full text acquired if determined to be relevant.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Rating Scheme for the Strength of the Evidence

Quality of Evidence Assessment*

I: Evidence obtained from at least one properly randomized controlled trial

II-1: Evidence from well-designed controlled trials without randomization

II-2: Evidence from well-designed cohort (prospective or retrospective) or case-control studies, preferably from more than one centre or research group

II-3: Evidence obtained from comparisons between times or places with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of treatment with penicillin in the 1940s) could also be included in this category

III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees

*Adapted from the Evaluation of Evidence criteria described in the Canadian Task Force on Preventive Health Care.

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

The evidence obtained was reviewed and evaluated by the members of the Expert Workgroup established by the Society of Obstetricians and Gynaecologists of Canada.

The quality of evidence was evaluated and recommendations made using the criteria described by the Canadian Task Force on Preventive Health Care (see the "Rating Scheme for the Strength of the Evidence" and the "Rating Scheme for the Strength of the Recommendations" fields).

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Not stated

Rating Scheme for the Strength of the Recommendations

Classification of Recommendations†

A. There is good evidence to recommend the clinical preventive action

B. There is fair evidence to recommend the clinical preventive action

C. The existing evidence is conflicting and does not allow to make a recommendation for or against use of the clinical preventive action; however, other factors may influence decision-making

D. There is fair evidence to recommend against the clinical preventive action

E. There is good evidence to recommend against the clinical preventive action

L. There is insufficient evidence (in quantity or quality) to make a recommendation; however, other factors may influence decision-making

† Adapted from the Classification of Recommendations criteria described in the Canadian Task Force on Preventive Health Care.

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

Internal Peer Review

Description of Method of Guideline Validation

This clinical practice guideline has been reviewed and approved by the Executive and Council of the Society of Obstetricians and Gynaecologists of Canada (SOGC).

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Appropriate management of female sexual concerns

Potential Harms

In building a comprehensive management plan, it is useful for health care providers to be aware of the benefits and risks of using estrogen, testosterone, or phosphodiesterase type 5 inhibitors for women with sexual concerns.

Qualifying Statements

Qualifying Statements

This document reflects emerging clinical and scientific advances on the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed. Local institutions can dictate amendments to these opinions. They should be well documented if modified at the local level. None of these contents may be reproduced in any form without prior written permission of the Society of Obstetricians and Gynaecologists of Canada.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Foreign Language Translations

Patient Resources

Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

Lamont J, Bajzak K, Bouchard C, Burnett M, Byers S, Cohen T, Fisher W, Holzapfel, Senikas V. Female sexual health consensus clinical guidelines. J Obstet Gynaecol Can. 2012 Aug;34(8):S1-56. [358 references]

Adaptation

Not applicable. The guideline was not adapted from another source.

Date Released

2012 Aug

Guideline Developer(s)

Society of Obstetricians and Gynaecologists of Canada - Medical Specialty Society

Source(s) of Funding

Society of Obstetricians and Gynaecologists of Canada

Guideline Committee

Society of Obstetricians and Gynaecologists of Canada's Expert Work Group

Composition of Group That Authored the Guideline

Principal Author: John Lamont, MD, Hamilton ON

Contributing Authors: Krisztina Bajzak, MD, St. John's NL; Céline Bouchard, MD, Quebec QC; Margaret Burnett, MD, Winnipeg MB; Sandra Byers, PhD, Fredericton NB; Trevor Cohen, MD, Victoria BC; William Fisher, PhD, London ON; Stephen Holzapfel, MD, Toronto ON; Vyta Senikas, MD, Ottawa ON

The literature searches and bibliographic support for this guideline were undertaken by Becky Skidmore, Medical Research Analyst, Society of Obstetricians and Gynaecologists of Canada.

Financial Disclosures/Conflicts of Interest

Disclosure statements have been received from all authors.

Guideline Status

This is the current release of the guideline.

Guideline Availability

Electronic copies: Available in Portable Document Format (PDF) from the [Society of Obstetricians and Gynaecologists of Canada \(SOGC\) Web site](#) . Also available in French from the [SOGC Web site](#) .

Print copies: Available from the Society of Obstetricians and Gynaecologists of Canada (SOGC), La société des obstétriciens et gynécologues du Canada (SOGC) 780 promenade Echo Drive Ottawa, ON K1S 5R7 (Canada); Phone: 1-800-561-2416.

Availability of Companion Documents

The appendix of the [original guideline document](#) contains resources and websites available on female sexuality and related issues.

Patient Resources

The following is available:

- What is a healthy sex life? Women's health information. Electronic copies: Available from the [Society of Obstetricians and Gynaecologists of Canada Web site](#) .

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors

or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC Status

This NGC guideline was completed by ECRI Institute on March 18, 2013.

Copyright Statement

This NGC summary is based on the original guideline, which is subject to the guideline developer's copyright restrictions.

Disclaimer

NGC Disclaimer

The National Guideline Clearinghouse[®] (NGC) does not develop, produce, approve, or endorse the guidelines represented on this site.

All guidelines summarized by NGC and hosted on our site are produced under the auspices of medical specialty societies, relevant professional associations, public or private organizations, other government agencies, health care organizations or plans, and similar entities.

Guidelines represented on the NGC Web site are submitted by guideline developers, and are screened solely to determine that they meet the NGC Inclusion Criteria which may be found at <http://www.guideline.gov/about/inclusion-criteria.aspx>.

NGC, AHRQ, and its contractor ECRI Institute make no warranties concerning the content or clinical efficacy or effectiveness of the clinical practice guidelines and related materials represented on this site. Moreover, the views and opinions of developers or authors of guidelines represented on this site do not necessarily state or reflect those of NGC, AHRQ, or its contractor ECRI Institute, and inclusion or hosting of guidelines in NGC may not be used for advertising or commercial endorsement purposes.

Readers with questions regarding guideline content are directed to contact the guideline developer.